

## **HHA PPS MAILBOX QUESTIONS**

### **VOLUME I, JANUARY 2001 – Batch 3**

The questions below, which in some cases have been paraphrased, were sent to: [HHPPSQuestions@HCFA.gov](mailto:HHPPSQuestions@HCFA.gov) during the period referenced above, on the Home Health Prospective Payment System (HH PPS). It is our intention to continue to answer questions that come into that mailbox in monthly batches, and post those answers at: [www.hcfa.gov/medlearn/refhha.htm](http://www.hcfa.gov/medlearn/refhha.htm). In cases where time was needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

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### **General Terms/Acronyms**

**The following terms/acronyms may not be spelled out/explained above or elsewhere in this document:**

**Case Mix** = Characteristics of a patient affecting cost of treatment; for HH PPS, these include the patient's clinical and functional condition, as well as related service demands

**HH** = home health

**HHA** = home health agency

**HCFA** = Health Care Financing Administration, the Federal Agency administering Medicare

**HHRG** = Home Health Resource Group, the payment group for HH PPS episodes

**HIPPS** = Health Insurance PPS, a code representing a PPS payment group on a Medicare institutional claim, placed in Form Locator 44

**HCPCS** = HCFA Common Procedure Coding System, individual codes, representing medical services or items in Form Locator 44 of Medicare institutional claims

**IPS** = Interim Payment System, the legislated system for paying cost-reimbursed home care under Medicare from 1998 until HH PPS.

**LUPA** = Low Utilization Payment Adjustment, an episode of four or fewer visits paid by national standard per visit rates.

**MSA** = Metropolitan Statistical Area, a series of codes representing geographic locations put on Medicare HH claims so that payment is commensurate with the location in which services are delivered.

**OASIS** = Outcome Assessment Information Set. The standard assessment instrument required by HCFA for use in delivering home care.

**Outlier** = An addition to full episode payment when costs of delivering services exceed a fixed loss threshold.

**RHHI** = Regional Home Health Intermediary. Medicare fiscal intermediary specializing in the processing of hospice and home health claims.

## VOLUME I, Batch 3, HH PPS Billing QUESTIONS and ANSWERS

### **HH PPS and General Policy:**

#### **Payment Rates:**

Q1 . Currently there are many variables that come into play when calculating the payment for any given episode, including:

**"standard episode payment"** - \$2,115.30 as of October 1, 2000, for a full budget-neutral 60-day episode (*standardized prospective payment*).

**"episode weight"** - determined from the HIPPS code (HHRG) submitted on the claim, representing a payment group based the case mix of the patient (*case mix index for group*)

**"labor portion ratio"** – currently .77668, the labor-related proportion of costs anticipated in episode payments

**"geographic wage index"** - determined from the MSA code submitted on the RAP or claim, used in determining site-specific payment (*wage index factor*).

**"standard per visit rates"** – per visit payments for each HH discipline set forth in HH PPS regulation, used in paying LUPA episodes and making outlier determinations (*national standard per visit rates*).

I am assuming that it is possible and in fact likely that one or more of these rates/factors will change in the future. Given this, my questions are:

- For each of the "variables" included in the computation of the payment of an episode, how likely is it that it will change at some point in the future?
- For each of the "variables" included in the computation of the payment of an episode, how soon is the earliest it would change, and are any changes currently planned?
- For each of the "variables" included in the computation of the payment of an episode, what is the logic that will be used in determining whether to use the "old" variable value or the "new" variable value?

**A1. Often, law requires rate changes. Law also stipulates when such changes will go into effect. For example, the Benefit Improvement and Protection Act of 2000 (BIPA 00), passed in December of 2000, required rate changes for home health prospective payments going back to the inception of the system (October 2000). It was stated these changes would be implemented in the middle of the federal fiscal year (April 2001). Therefore, payments were increased in the second half of that year, so that cumulative payments would approximate those that would have been expected if the change had been able to be made at the beginning of the year.**

**If HCFA has flexibility in implementing a rate change for institutional providers like home health agencies, the change will usually be made effective at the beginning of the federal government fiscal year each October 1. The home health prospective payment system (HH PPS) began with the advent of the 2001 federal fiscal year, and to the extent possible, routine or annual updates to this system will be scheduled to become effective each October 1. For example, changes in inflation factors used in rates must be reviewed annually, and would be effective each October 1.**

**All the rate changes mentioned above, except for the change required for BIPA 00, are set forth in regulation and therefore require regulatory change. This applies not only to changes in rate amounts, but also changes to calculation methodology or logic. Changes affecting existing regulation, such as the regulations implementing HH PPS, must be published in a notice in the Federal Register. An update notice with rate information for the 2002 Fiscal Year is expected this summer.**

**These notices must be done at least three months in advance of the expected effective date (i.e., no later than July 1 for October 1), so that Medicare Contractors, providers and other affected parties have time to implement. Such regulatory or even statutory changes will almost always be paralleled by instructions, usually in the form of Medicare Program Memoranda, issued by HCFA to Medicare contractors and available to the public on HCFA's website ([www.hcfa.gov](http://www.hcfa.gov)).**

**(HH) Consolidated Billing:**

**Q2 . Where can I get the most recent non-routine supply list ?**

**A2. The latest publication of the list of non-routine supplies subject to HH PPS consolidated billing is Program Memorandum AB-01-65 released on April 26, 2001. This publication is available on the HCFA website:**

**([www.hcfa.gov/pubforms/transmit/memos/comm\\_date\\_dsc.htm](http://www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm)).**

**A list of the supplies is also available elsewhere on the HCFA web in relation to general HH PPS information:**

**([www.hcfa.gov/medlearn/refhha.htm](http://www.hcfa.gov/medlearn/refhha.htm)).**

**The specific list is likely to change each year since the HCPCS code list is updated annually by HCFA.**

**Catheter Supplies:**

Q3. I've read the policies and would appreciate clarification on supplies for central line catheter care. For example, if a patient has a central line which requires daily flushing, or a port which requires monthly flushing, would the supplies be billed by the home health agency, or by the IV provider who would be billing secondary insurance? This would be a situation where the patient is not receiving any IVs.

**A3. If the infusion company is furnishing the rest of the durable medical equipment (DME), the flushing solution would be part of the package of services provided by the home health agency. The infusion company should leave the flushing fluid for the home health nurse to use. The nurse might need to provide her own gloves and syringe.**

**Payment Adjustments:**

Q4. We had two patients who went in the hospital and upon resumption of care, we generated a SCIC adjustment to episode payment. Upon discharge, we submitted our final claim reflecting both the HIPPS codes (HHRGs) before and after hospitalization, and services provided under each HIPPS. We were paid up until date of discharge, not the end of the episode. I had not seen any mention of this difference before we experienced it ourselves. One of the patients in this case was admitted to a Hospice program, and yet we still were not paid to the end of the episode.

**A4. As early as the Proposed Rule [Regulation] implementing HH PPS, significant change in condition adjustments (SCICs) to full episode payment were described as having a duration of: " the span of days from [and including] the first billable service date through [and including] the last billable service date . . . for each case mix assignment [HIPPS applicable to the episode in question]". This definition has remained consistent in all HH PPS regulations and billing instructions. Briefly, a SCIC adjustment is applied each time a change in patient condition is significant enough to require a change in physician orders and a reassessment of the patient with the OASIS assessment tool within the 60-day episode.**

**In the example you provide above, it seems the date of discharge was equal to the last billable service date under the last HIPPS code applicable to the episode. If so, correct payment was made in your case. When a SCIC adjustment applies, payment would not be made through the end of the episode unless that day was also the last billable service date for the episode. Remember that there are two exceptions to the requirement to bill SCIC adjustments despite changes in patient condition: (1) if the re-assessment results in the same case mix grouping (HIPPS**

**code output), and, (2) if reporting a subsequent HIPPS would result in a financial loss for an agency that is now expected to serve a sicker patient.**

Q5. When a patient is discharged from an agency, for whatever reason, and readmitted within the 60-day episode, what happens to the subsequent period of time (that period of time starting at the time of readmission) for payment purposes? For example, patient was admitted, and then discharged on Day 20, readmitted on Day 40. What happens from Day 40 to 60?

**A5. In your example above, the episode clock would be re-set after the first discharge. You would receive a partial episode payment (PEP) adjustment of 1/3 (20/60) of the full episode payment for the first episode, assuming no other payment adjustments applied. What had been Day 40 would then be Day 1 of the next episode. [Revised August 2001.]**

### **HH PPS Claim Elements:**

#### **Patient Status Codes:**

Q6. We have several questions related to the Patient Status codes (Form Locator 22 of the UB-92 Claim). If the patient is in the middle of the episode and goes in to the hospital short-term, and then is transferred to the SNF, which code do we use? What date do we use? If the patient is admitted to the hospital short-term and subsequently dies in the hospital, which code do we use and which date?

**A6. HCFA does not require use of a particular patient status code on the HH PPS claims. Any NUBC-approved code the provider believes appropriate may be used. Note the NUBC, National Uniform Billing Committee, is the standard-making organization governing both the UB-92 claim form as well as the codes used on that form. NUBC codes can be found in HCFA Manuals containing claims processing instructions, such as the Home Health and Medicare Intermediary Manuals.**

**For the particular situation you describe, patient status code 03, "discharged /transferred to SNF" (skilled nursing facility), sounds most appropriate. Other patient status codes commonly used in HH PPS are: 01 - "discharged to home/self care", 30 - "still a patient", 20 - "expired", and 06 - "discharged transferred to home/under HHA care". Note that this last code, 06, is the one patient status code that will affect payment in and of itself. A partial episode payment (PEP) adjustment will be applied in transfer or discharge and re-admission to the same HHA situations, shown with patient status code 06, when more home care is provided in the same 60-day period.**

#### **Change of HIPPS/Recertification:**

Q7. If you have a patient that is still active, and was billed under one HIPPS code on the initial RAP, then the recertification was done four days before the final claim and

HIPPS code has changed, do you put the new HIPPS code on the final claim, or the same HIPPS code as on the RAP?

**A7. This depends on if the OASIS assessment driving the recertification or other need. If assessment was being done for re-certification of the upcoming episode period, the HIPPS code generated by that assessment would be only applied to the new episode once it began. The HIPPS code used on the previous episode's RAP would be used on the final claim closing out that episode, assuming no significant change in condition (SCIC) adjustment occurred during that 60-day period.**

**If an assessment is done within an episode because of a SCIC, a HIPPS different from the one reported on the RAP for the same episode may have to be reported, even if that assessment occurred only four days from the end of the episode. See Question 3 above for more detail on SCIC adjustments.**

### **Other HH PPS Information:**

#### **Sequential Billing:**

**Q8 . We believe our RHHI has told us we are required to bill sequentially by episode. I know that we have to bill a RAP before we bill a final claim for any episode, but I was not aware that we could not submit the RAP for a second episode before we do for a first. In our case, we submitted a LUPA for a recertified episode, but had not submitted the RAP for the initial episode. Please clarify.**

**A8. You are correct that you may bill a RAP for a subsequent episode before you bill the claim of the previous episode for which you have already submitted a RAP.**

**However, we believe your RHHI is guiding you to avoid some current problems HCFA is having with Medicare claims processing systems. Currently, the systems cannot open a previous episode for a given patient if a subsequent episode is already billed. Why? Because if the 60-day period created by the previous episode RAP overlaps at all with the subsequent episode period, the previous episode RAP will be rejected. HCFA is working to have this problem fixed, but in the interim, we believe your RHHI is wisely advising you to avoid this problem in its entirety by billing as timely and as much in sequence as possible.**

**Note too that it is advisable to bill the claim of the episode before expiration of the 120-day period from the start of the episode, after which the RAP will be usually be auto-cancelled. Although following a RAP with a bill in this time frame is not required, the procedure for re-billing an auto-cancelled RAP has proved protracted for some providers, and HCFA joins the RHHIs in recommending billing before the auto-cancellation point whenever possible.**

**Finally, not all episodes require the billing of a RAP. If you have an episode which you know from the outset will be a LUPA, an episode of four or fewer visits, you**

may choose to submit only a claim for that LUPA episode. This type of claim is referred to as a "No-RAP LUPA" in training materials. However, HHAs that choose to bill a RAP in these situation will not be penalized by Medicare, since any possible overpayments resulting from this billing approach will automatically be recouped when the claims for the episode is processed.

### **Dual Eligibles:**

Q9 . Say a patient is a receiving skilled nursing visit one time per week, and the primary payer is Medicaid, because under Medicare home health, the reason the beneficiary is receiving this particular service is not covered. This same patient then injures a leg, and is in need of physical therapy at home, which Medicare will cover. How do you go about changing primary payer from Medicaid to Medicare?

What type of OASIS assessment is due?

**A9. In the example above, for Medicare billing purposes, it appears the patient is just becoming eligible for home care with the leg injury. There must be a plan of care and OASIS assessment supporting this need. The OASIS assessment will generate a HIPPS code, which will enable billing of a RAP (request for anticipated payment) to Medicare as the "new" primary payer. The RAP opens a HH PPS episode, and results in the first of two split payments for that episode. The episode would start with the first date of service for the leg injury, not before. Note that while the plan of care does not have to be signed when the RAP is submitted, it does need to be signed before the claim is billed at the end of the episode, remitting the other split percentage payment.**

Medicaid, the payer of last resort, would not be billed until after Medicare had been billed and paid for the entire episode, which itself could last up to 60 days. Federal Medicare staff are working with State agencies to be certain they know of these new time frames for Medicare payment for home care, since there have been issues with Medicaid timely filing requirements since the advent of HH PPS.

Finally, whenever an episode of care begins under Medicare, a start of care assessment is required is required for OASIS.

### **OASIS:**

### **Errors and Billing:**

Q10. How can I resubmit or otherwise get the corrected HIPPS data to HCFA? The HIPPS codes in our software are correct, however, prior to mid-November 2000, the codes were incorrectly interpreted when submitted because of a problem with our software, so we received a 257 warning that did not match the calculated value on Final Validation Report. Those problems have been corrected by the vendor, but I cannot resubmit as these assessments as they were not rejected, thus the corrected assessments

are rejected as being duplicative. How do I resolve this issue so that our billing HIPPS data match what is on file with submitted OASIS data at HCFA?

**A10. There are 2 HIPPS values stored on the State database. One is what the agency submitted. The other is what the OASIS State System calculates when the record was submitted. If the agency wants the one they submit to match the one calculated, and all the other data in the record is correct, they can submit the same record with the Correction Number incremented by 1. This is correction option number 3 in the HAVEN software, and should be available in your software if the vendor is following the HCFA-defined data specifications. These assessments will not be rejected.**

**Regarding billing, the HIPPS code(s) derived from the OASIS transmitted to the State should match an assessment supporting the episode found on either the RAP or claim for the same episode.**

**If an error in the HIPPS code affects the RAP, the RAP must be cancelled and re-billed. RAPs cannot be adjusted.**

**If a claim has already been billed, only the claim, not the RAP need be changed. Unlike a RAP, the claim may be adjusted to change the HIPPS code, using the condition code D9 in Form Locators 24-30 of an adjustment claim.**

#### **Timing of Recertification:**

**Q11. Is there any possibility of a change in the requirement that Medicare PPS OASIS assessments need to be completed in the last five days of the certification period? If not, what is the potential penalty for completion prior to the 55th day of a certification period? The reason for this is the question of the need to do non-billable visits to complete both the OASIS and the required 485 (verbal order) for the recertification.**

**A11. Currently, there are no plans to revise the requirements for the collection of OASIS data. Collecting standardized data on patients at uniformly defined time points means that certification periods need to be less flexibly defined. As such, noncompliance with the required time points may result in deficiency citations. In managing the patient's care, the visit schedule should be monitored to include a visit during this time. If multiple disciplines are providing care, the assessment and data collection can be done by a member of another discipline. A patient assessment could be done during an aide supervisory visit. In nearly all situations encountered by agencies currently using OASIS, agency staff has been able to schedule visits to occur within the 5-day recertification period. With the advent of PPS, it is even more crucial that HHAs conduct their follow-up assessments during the last 5 days of the 60-day episode, as the subsequent episode's payment will be derived from this assessment.**

**Agencies may find they need to review, and possibly revise, several of their previous policies and procedures in successfully implementing efficient OASIS data collection. Refer to the OASIS User's Manual, Chapters 5, 6, and 9 for more guidance in this area.**